

Master Application

2008 V1 CC.

<u>Company Name</u>	<u>Business Address</u> (street, city, state, zip) <u>Billing Address</u> (if different)	<u>Desired Effective Date</u>
<u>Principal Contact</u>	<u>Telephone</u>	<u>Fax</u>
<u>Chamber of Commerce Affiliation</u>	<u>Type of Business</u> <input type="checkbox"/> Corporation <input type="checkbox"/> Proprietorship <input type="checkbox"/> Partnership <input type="checkbox"/> Other	<u>Date Business Established</u>

Best Buy HSA PPO Plans					
		Deductible (Ind/Fam)		After Deductible Plan Co-pay (%)	
		In Network	Out-of Network	In Network	Out-of Network
	Plan 1	\$1500/3000	\$3000/6000	100	80
	Plan 2	\$1500/3000	\$3000/6000	80	60
	Plan 3	\$2000/4000	\$4000/7000	100	80
	Plan 4	\$2000/4000	\$4000/7000	80	60
	Plan 5	\$3000/6000	\$6000/9000	100	80
	Plan 6	\$3000/6000	\$6000/9000	80	60

<u>Employer Contribution</u> Minimum 50% for Individual and 33% for Family Individual _____% Family _____%	<u>SIC code (4 digits)</u> [_____]	<u>Nature of Business</u>
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Eligibility Waiting Period* None ___ 1 Mos. ___ 2 Mos. ___ 3 Mos. ___ 4 Mos. ___ 5 Mos. ___
 *Definition - This is the period from the date of hire to the time a new employee is eligible to be added to the company health plan.

List ALL full-time employees working 30 or more hours per week (Owners Included)

Name	Date of Birth	Ind. (I) Dual (D) Family (F)	Covered by Spouse's health plan		Present Carrier/HMO Name or None	Current Monthly Premium
			YES	NO		

Did your company within the last 12 months make any late payments for health insurance? Yes ___ No ___
 If Yes, how many times? ___
 Did your company cancel more than 2 health plans in the last 4 years? Yes ___ No ___

Certification

1. I understand that all premiums for health/dental insurance are due on or before the 1st day of the month of coverage
2. I understand if premiums are not received by the 1st day of the month of coverage, NBT has the option of assessing a 1.5% late charge on the balance due.
3. I understand that if premiums are not received by the 1st day of the month, NBT has the option of terminating coverage effective that date.
4. I certify that I have not misrepresented eligibility of an employee or misrepresented information needed to determine group size, group participation rate, or group premium rate.
5. I acknowledge that Northeast Business Trust, Inc. is a sales and billing agent and is not responsible for payment of claims on our behalf.

<u>Signature</u> (Authorized Employer Representative)	<u>Title</u>	<u>Date</u>
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Forward All Materials to: Northeast Business Trust P.O. 5059 Billerica, MA 01822-5059